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No. 99-

IN THE
Supreme Court of the United States

JOHN A. BUSSELL, M.D.,

Petitioner,

v.

PROVIDENT LIFE & ACCIDENT INSURANCE CO., *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. Whether a litigant's constitutional right to due process, the doctrine of stare decisis, or public policy compel an appellate court to (a) follow its own published decisions and (b) apply a state's controlling legislative plan.

II. Whether an appellate court's refusal to apply a state's controlling legislative plan constitutes a violation of the Tenth Amendment to the United States Constitution.

PARTIES TO THE PROCEEDINGS

Petitioner is John A. Bussell, an individual.

Respondents are Provident Life and Accident Insurance Company, John Hancock Mutual Life Insurance Company[1] and Paul Revere Life Insurance Company (collectively "the insurers.")

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1. Provident acquired Hancock's disability line (CR 54, p. 23), and both are represented by the same counsel. They will be referred to jointly as "Provident."

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STATEMENT OF JURISDICTION

The memorandum decision of the Ninth Circuit Court of Appeals was entered on November 23, 1999. The Court of Appeals entered an order denying a timely petition for rehearing and petition for rehearing en banc on January 4, 2000. (App. F).

The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

This case involves the Fifth Amendment to the United States Constitution which provides, in pertinent part: "No person shall be . . . deprived of life, liberty, or property, without due process of law. . . ."

This case also involves the Tenth Amendment to the United States Constitution which provides: "The powers not delegated to the United States by the Constitution, nor

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2. The following abbreviations will be used in this petition: "App." refers to the Appendix attached to this petition; "ER" refers to the Excerpts of Record filed in the Court of Appeals; "CR" refers to the entries on the District Court's Civil Docket; and "RT" refers to the Reporter's Transcript filed in the Court of Appeals.

prohibited by it to the States, are reserved to the States respectively, or to the people."

Finally, this case involves certain provisions of the California Insurance Code.[3] § 10110.1(b) provides:

> An individual has an unlimited insurable interest in his or her own life, health, and bodily safety and may lawfully take out a policy of insurance on his or her own life, health, or bodily safety and have the policy made payable to whomsoever he or she pleases, regardless of whether the beneficiary designated has an insurable interest.

§ 10350.2 provides:

> A disability policy shall contain a provision which shall be in one of the two forms set forth herein. Policies other than noncancellable policies shall use Form A. Noncancellable policies shall use either Form A or Form B. In Form B the clause in parenthesis in paragraph (a) may be omitted at the insurer's option. Paragraph (a) in Form A shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during the initial two-year period, nor to limit the application of Sections 10369.2 to 10369.6, inclusive, in the event of misstatement with respect to age or occupation or other insurance.

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3. Unless otherwise stated, all further statutory references shall be to the California Insurance Code.

Form A.

Time Limit on Certain Defenses: (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to avoid the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

Form B.

Incontestable: (a) After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

STATEMENT OF THE CASE

In order to fully grasp the insidious manner by which Bussell had been deprived of a fair trial in this action, it is necessary to consider the acts taken by the insurers both before this action was initiated, and throughout the course of the trial and appeal.

A. Events Leading up to the Initiation of This Action

For 17 years, Bussell was the primary pediatric and one of four adult cardiac anesthesiologists at Cedars-Sinai Medical Center. (RT 845, 847.) Consistent with § 10110.1(b), between 1987 and 1992, Bussell purchased "own occupation" disability policies from various insurance companies. (RT 866, 875, 877-880.) By the time of his disability, Bussell was paying nearly $40,000 per year in premiums for these policies. (RT 1114.) Under such policies, benefits would be payable in the event Bussell were to suffer physical or mental impairment of his ability to perform the material duties of a pediatric and adult cardiac anesthesiologist. Thus, benefits would be payable even though Bussell might be able to perform in a less demanding medical field, or any other occupation.

Bussell has "severe degenerative arthritis . . . in the thoracic area." (ER 7, p. 4.) He also has "a severe [T9] compression fracture." (ER 7, p. 5.) On September 2, 1992, due to the negligence of a store at which he was shopping, Bussell fell. The fall "flared up a pre-existing degenerative arthritis, not only in his thoracic spine, but in his lumbar spine." *Ibid.* Since the injury, Bussell experiences severe pain and muscle spasms when repeatedly bending forward for prolonged periods of time and performing certain maneuvers

requiring various movements of his upper spine. (RT 245.) Administering cardiac anesthesia by bending over patients for prolonged periods, performing intubation, cardiopulmonary resuscitation and focusing on critical concentration adjustments of life sustaining intravenous medications is impossible for an anesthesiologist distracted by severe pain and muscle spasms. (RT 245-246.)

Following policy terms, Bussell submitted claims to the insurance companies. (RT 949.) Some honored their commitments without hesitation. (RT 929-930.) Respondent insurers were not among them, instead demanding Bussell undergo *numerous* medical examinations, both physical and mental. (RT 1484.) Multiple doctors, including some who had been hired as independent medical examiners by the insurance companies, concluded that Bussell was in fact *disabled from performing cardiac anesthesiology*. However, the insurers were not interested in these doctors' opinions. Instead, they hired highly paid "experts" who could provide them with more favorable testimony.

Revere denied Bussell's claim immediately. (RT 1152.)[4] Provident paid intermittently. *Ibid.* Provident initially attempted to coerce and intimidate Bussell into surrendering the policies in exchange for two months of benefits by asserting they were void since he was allegedly "overinsured" and he supposedly submitted incomplete insurance

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4. As the District Court noted in denying Revere's summary adjudication motion, Bussell presented evidence which demonstrated that Revere decided to deny his claim *before* conducting an investigation. Of course, since the District Court bifurcated the coverage issue from the bad faith issues, Bussell never got the opportunity to present this evidence to the jury.

applications. (CR 71, p. 9.)[5] After Bussell refused to surrender the policies, Provident paid benefits under a reservation of rights. Then Provident stopped paying benefits, only to resume making payments a few months later. Finally, after Bussell filed bankruptcy (as a result of this lengthy and costly litigation), Provident ceased making payments. (CR 54, p. 13.)

B. The Proceedings Below

On March 18, 1994, Provident filed a complaint seeking a declaratory judgment and restitution. (CV 94-1756 RAP; CR 1.) Therein, Provident asserted Bussell was not entitled to benefits because: (1) he purportedly did not have an insurable interest in the benefits; and (2) he supposedly was not disabled. Provident sought a judicial declaration that Bussell was not entitled to benefits, and restitution of any money Bussell received. The basis for the District Court's jurisdiction was diversity of citizenship.

On June 10, 1994, the District Court (Hon. David V. Kenyon) dismissed, with prejudice, Provident's claims which were based on allegedly incomplete insurance applications since these claims were precluded under the incontestability provisions of the pertinent policies. The District Court also dismissed Provident's overinsurance claims since § 10110.1(b) provides that an insured has an *unlimited*

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5. Edwin Ruiz, Provident's Assistant Vice President of Claims, indicated that, had the insurers known about Bussell's other policies, Provident (and its subsidiaries) would have refused to sell insurance to Bussell. This type of behavior constitutes an illegal boycott and, under the McCarran-Ferguson Act (15 U.S.C. §§ 1011, *et seq.*), removes Provident's immunization from the Sherman Antitrust Act. *St. Paul Fire & Marine Insurance Co. v. Barry*, 438 U.S. 531, 552 (1978).

insurable interest in his own life, health and bodily safety. (App. 42a-43a.) Thus, Provident's action could only proceed on the limited issues of whether Bussell was disabled within his *own occupation*, and whether Provident was entitled to restitution.

On July 26, 1994, Bussell filed an action against Revere asserting that, by denying his claim for disability payments, it breached its contract with him and, due to its unfair claims handling practices, it also breached the implied covenant of good faith and fair dealing. (CV 94-5987.)

On September 15, 1994, Bussell filed a counterclaim against Provident alleging violation of the implied covenant of good faith and fair dealing by forcing him to litigate in order to obtain benefits under the policies. Specifically, Bussell asserted Provident acted in bad faith by:

> unreasonably and without proper cause or adequate investigation bringing the instant [declaratory judgment] action against [Bussell], requiring [Bussell] to incur substantial attorneys' fees and costs to retain the benefits that he was entitled to under the Policies, threatening to take back all of the payments made to [Bussell] under the Policies, attempting to induce [Bussell] to surrender the Policies in return for payments far less than the amounts due under the Policies in order to avoid the substantial costs of litigation, knowingly and wrongfully inflicting on [Bussell] severe emotional distress by bringing the instant action and by seeking to recover all disability benefits paid to [Bussell] under the Policies, with interest, and using intimidation and

> economic pressure to force [Bussell] to agree to surrender the Policies for less than their full value. (CR 15, p. 4.)

On October 10, 1995, over Revere's objection, the declaratory relief, restitution, breach of contract and bad faith claims were consolidated. (CR 38.)

On February 16, 1996, the insurers filed separate motions for summary adjudication of Bussell's bad faith and punitive damages claims. (CR 54, 56.) Provident asserted that: (1) in light of the facts known at the time, as well as the "unsettled nature of California's insurance law," a legally adequate basis to file the instant action existed; and (2) Bussell had no evidence to support his claim for punitive damages. Revere alleged that: (1) Bussell's breach of contract and bad faith claims were preempted by ERISA; and (2) there was no basis to support an award of punitive damages.

On June 27, 1996, concluding the conflicting medical evidence constituted reasonableness, as a matter of law, for Provident to have filed the declaratory judgment action, the District Court granted Provident's motion for summary judgment. (CR 90, p. 19; ER 2, p. 19.) As for Revere's motion, the District Court concluded that ERISA was inapplicable because Bussell was an independent contractor, not an employee. (CR 90, pp. 12-13; ER 2, pp. 12-13.) Regarding punitive damages, the District Court noted:

> In the present action, Bussell has presented evidence to the Court from which a reasonable trier of fact could conclude that Paul Revere engaged in a *willful* campaign to ignore medical evidence that would *support a finding of disability*

> and the payment of benefits as provided in the policy. Furthermore, Bussell marshalls evidence to suggest that Paul Revere decided to deny coverage *before* conducting its investigation of Bussell's claim. (CR 90, p. 17; ER 2, p. 17; emphasis added.)

Trial commenced on October 7, 1997.[6] Despite Judge Kenyon's findings that the California Insurance Code prohibited Provident from contesting either that Bussell had an unlimited insurable interest or the statements contained in the insurance applications (App. 42a-45a), Judge Paez permitted the insurers to *repeatedly misrepresent* to the jury that Bussell was "overinsured" and had allegedly lied on his insurance applications.[7]

Moreover, the determination of whether a person has a physical or mental disability is a *medical question*. It should have been resolved by a complete evaluation of all the scientific facts without prejudicial material which might divert jurors' attention from the real question at issue.

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6. At the insurers' request, the District Court ordered the trial on the bad faith issues bifurcated from the disability issue. (CR 110, pp. 22-23; ER 3, pp. 22-23.)

7. The record does not reveal why Judge Kenyon had been removed from presiding over this action. However, following Judge Kenyon's order (which was favorable to Bussell) on the motion to strike portions of Provident's complaint, the matter was reassigned to Judge Richard A. Paez. That Judge Paez did not understand the legal significance of § 10110.1(b) (an insured has an ***unlimited*** insurable interest in his own life, health and bodily safety), or Judge Kenyon's ruling based thereon, is clearly reflected by his ruling that the insurers could "bring up the fact that [Bussell] *stockpiled* all of these insurance policies." (9/30/97 RT 112, emphasis added.) This legally erroneous ruling permeated and tainted the entire trial.

In light of the overwhelming medical evidence which proved Bussell's disability, the insurers knew they would lose the case if only the medical evidence was considered by the jury. In the words of the lead attorney for Provident, who acknowledged Bussell "has an objective back condition which can cause pain" (1/13/97 RT 14), and conceded "eleven doctors find [Bussell] to be disabled from his occupation . . ." (RT 2077-2078), if they were limited to the medical evidence, they would simply have to **"write [Bussell] a check."** (9/30/97 RT 91, emphasis added.)

Accordingly, the insurers embarked on a scheme whereby they introduced irrelevant, distorted and prejudicial material which they knew would enrage the jury against Bussell. Thus, the insurers introduced material that, before his disability, Bussell had ongoing financial obligations, had been named as a defendant in a medical malpractice action (failing to disclose that *every* physician in the operating room had been named as defendants) and, *nearly three years following the disability*, he filed bankruptcy. The insurers relentlessly exploited these issues as part of their character assassination of Bussell.

Unsatisfied that the foregoing would sway the jury, the insurers, *in direct violation of the District Court's orders on Bussell's motions in limine*, introduced evidence that Bussell drove a Mercedes, had lived in an expensive neighborhood and took his three children on family trips during their school breaks. The District Court properly excluded such evidence due to its prejudicial nature (9/30/97 RT 109-111) but the insurers, over Bussell's objections, repeatedly brought it to the jury's attention.

Still unsatisfied the foregoing tactics would result in a verdict in their favor, in closing argument, counsel for the insurers resorted to repeatedly providing information to the jury, over objections, which had no basis in the evidence presented at trial. (RT 1973-1974, 2027, 2037-2038, 2066-2067, 2071-2072, 2077.)

The insurers' goal was to paint Bussell with enough prejudicial non-medical evidence to make the jury jealous and confused, and therefore not believe him or the examining doctors. On the other hand, because of the bifurcation order, the jurors were not presented any evidence of the insurers' egregious conduct in handling Bussell's claims or evidence relating to the many millions of dollars the insurers have withheld from claimants as part of their pattern of fraudulently administering these specific types of policies.[8]

The insurers' egregious tactics succeeded. On November 7, 1997, after *seven days* of deliberating over the evidence presented, the jury returned a verdict in favor of the insurers. (CR 224.) A judgment was entered on December 11, 1997. (CR 273; ER 4.)

In short, Bussell was deprived of a fair trial through the calculated misconduct of counsel for the insurers, the erroneous evidentiary rulings (after there was a change in judges on the case) which permitted irrelevant and prejudicial material to be introduced to the jury and the bifurcation order

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8. Unfortunately, the Provident group of insurance companies (which includes Hancock, Revere and Unum) has made it standard operating procedure to deny disability claimants of the benefits under such policies. Nationwide, there are in excess of 3,000 actions pending between the Provident companies and their insureds concerning entitlement to payments under disability policies.

which precluded presentation of evidence of the insurers' fraudulent tactics and their financial gain therefrom. On December 19, 1997, Bussell filed a timely motion for new trial in which he raised these issues. (CR 275.) This motion was denied by the District Court on February 5, 1998. (CR 286; ER 5.)

Bussell timely filed a notice of appeal on March 5, 1998. (CR 288; ER 6.) In the course of the appellate proceedings, Bussell complained vociferously about the insurers' tactics and the erroneous evidentiary rulings which had deprived him of fair trial. Ultimately, in a brief memorandum decision, the Ninth Circuit Court of Appeals turned a deaf ear to Bussell's complaints, and a blind eye to both the applicable state legislation and the prior published opinions of the Ninth Circuit. (App. A.)

On December 6, 1999, Bussell filed a timely petition for rehearing and suggestion for rehearing en banc, specifically pointing out the inconsistencies between the memorandum decision and the applicable statutes and case law. This petition was summarily denied on January 4, 2000. (App. F.)

REASONS FOR GRANTING THE WRIT

I.

THE MEMORANDUM DECISION OF THE COURT OF APPEALS CONFLICTS WITH PRIOR PUBLISHED OPINIONS OF THE NINTH CIRCUIT

It is well established that the lower courts are compelled to follow the decisions of this Court. *State Oil Co. v. Khan*, 522 U.S. 3, 20 (1997). However, this Court has never squarely addressed the issue of whether, as a matter of constitutional due process, stare decisis or public policy, an appellate court must follow its own published opinions.

Obviously, a party may reasonably expect to receive the same level of justice (through consistent rulings) as any other party who presents the same factual and legal circumstances to a particular appellate circuit. Such an expectation is markedly enhanced where that circuit has published an opinion addressing virtually identical factual and legal issues.

Describing the necessity of intracircuit consistency, Professor Arthur D. Hellman has noted:

> First, the ideal of equality is violated when similarly situated persons receive disparate treatment because two panels of the same court have attached different legal consequences to facts that are identical in all relevant respects. Second, inconsistent appellate decisions create uncertainty about what the law requires or permits. That uncertainty encourages wasteful litigation; and where litigation cannot be avoided, the

> uncertainty adds to the costs and other burdens of court proceedings. Third, intelligent planning and structuring of transactions is frustrated when the relevant precedents in the governing jurisdiction give conflicting guidance on what the law is. Hellman, *Restructuring Justice: The Innovations of the Ninth Circuit and the Future of the Federal Courts*, Maintaining Consistency in the Law of the Large Circuit, p. 57 (Cornell University Press 1990).

Explaining the important role served by the doctrine of stare decisis, this Court has stated:

> *Stare decisis* reflects "a policy judgment that 'in most matters it is more important that the applicable rule of law be settled than that it be settled right.' " [Citations.] It "is the preferred course because it promotes the evenhanded, predictable, and consistent development of legal principles, fosters reliance on judicial decisions, and contributes to the actual and perceived integrity of the judicial process." [Citation.] This Court has expressed its reluctance to overrule decisions involving statutory interpretation, [citation], and has acknowledged that *stare decisis* concerns are at their acme in cases involving property and contract rights, [citation]. *State Oil Co. v. Khan*, *supra*, 522 U.S. at 20.

Ironically, while the Ninth Circuit has held that any three-judge panel of that court is bound by a prior published Ninth Circuit decision and cannot reconsider a decided issue unless an en banc decision, a Supreme Court decision, or

subsequent legislation undermines its precedential value, *United States v. Zarate-Martinez*, 133 F.3d 1194, 1200 (9th Cir. 1998); *United States v. Gay*, 967 F.2d 322, 327 (9th Cir. 1992), the panel in the instant case chose to ignore this pertinent authority. Moreover, as set forth in detail, *post*, with regard to the particular evidentiary issues presented by this appeal, the panel did not follow (let alone address) its prior published decisions. Finally, the panel also ignored the Ninth Circuit's prior case law which interpreted the substantive state legislation applicable to the case at bench. Simply stated, an appellate court which acts in this manner deprives a litigant of a fair and meaningful procedure, the cornerstone of the due process clause of the Fifth Amendment. *In re Murchison*, 349 U.S. 133, 136 (1955) ["A fair trial in a fair tribunal is a basic requirement of due process"]; Nowak & Rotunda, *Constitutional Law*, Procedural Due Process, § 13.8, p. 551 (5th ed., West Publishing Co., 1995) ["The essential guarantee of the due process clause is that of fairness"].

In its memorandum decision, the panel rejected Bussell's argument that Judge Kenyon's order granting Bussell's motion to dismiss and/or strike portions of Provident's complaint (App. E) prohibited the insurers from asserting to the jury throughout the trial the legally insupportable and irrelevant concept that Bussell "stockpiled" disability insurance policies. Citing *United States v. Cote*, 51 F.3d 178 (9th Cir. 1995), the panel noted that the "doctrine [of law of the case] only applies to issues actually decided by the first court" and concluded that "Judge Kenyon ruled only that the policies were not void on a theory of overinsurance; he did not consider whether the evidence of stockpiling

insurance was relevant to Bussell's disability claim." (App. 3a).[9]

While it cannot be disputed that the *Cote* court held "that the law of the case acts as a bar only when the issue in question was actually considered and decided by the first court," 51 F.3d at 181, the Ninth Circuit went on in *Cote* to acknowledge that "the doctrine applies to a court's 'explicit decisions as well as those issues decided by necessary implication,' " *ibid.*, quoting *Eichman v. Fotomat Corp.*, 880 F.2d 149, 157 (9th Cir. 1989). When the scope of Judge Kenyon's order is compared to the earlier rulings involved in *Cote* and *Eichman*, it becomes readily apparent that the case at bench is distinguishable from *Cote* and is governed by *Eichman*.

In *Cote*, an appellee asserted that law of the case applied where, in a former appeal, the appellant filed an unsuccessful petition for rehearing containing a footnote discussing the same issue presented by the current appeal. The Ninth Circuit correctly rejected the appellee's assertion, holding that "[t]he summary denial of the petition does not indicate the court considered and decided the issue presented by the [appellant] in the footnote annexed to its rehearing argument." *United States v. Cote*, *supra*, 51 F.3d at 181.

In *Eichman*, the Ninth Circuit determined in an earlier appeal that the appellant could not avoid the doctrine of res judicata based on his theory of fraudulent concealment. In a subsequent appeal, the appellant contended that the earlier

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9. What the panel failed to grasp was that the insurers presented the concept of "stockpiling" to the jury as "overinsurance." Obviously, this change in semantics did not alter the concept.

holding concerning fraudulent concealment vis-à-vis res judicata could not constitute law of the case on the issue of fraudulent concealment vis-à-vis the applicability of the statute of limitations since that precise issue had not been actually decided. In rejecting the contention, the Ninth Circuit held that, although it did not specifically address fraudulent concealment in terms of the statute of limitations in the earlier opinion, under the rationale of the earlier decision, its "conclusion that Eichman had failed to demonstrate fraudulent concealment to avoid the doctrine of res judicata . . . was equally applicable to his argument that the statute of limitations should not bar his claims." *Eichman v. Fotomat Corp.*, *supra*, 880 F.2d at 157.

In the instant case, in dismissing Provident's claims for rescission and reformation, Judge Kenyon explicitly rejected Provident's assertion that, because Bussell allegedly purchased insurance policies in an amount purportedly in excess of his actual earnings, he had no insurable interest. Judge Kenyon's ruling was premised upon § 10110.1(b) which provides, in pertinent part: "An individual has an *unlimited insurable interest* in his or her own life, health, and bodily safety. . . ." (Emphasis added; *see* App. 42a-43a).

Provident also pressed its claims for rescission and reformation based on its contention that it made a unilateral mistake in issuing the policies to Bussell because he purportedly misrepresented his income and the existence of the other insurance when he applied for the Provident policies.[10] Judge Kenyon dismissed these claims based on

10. The evidence presented at trial demonstrated that, contrary to the insurers' unsupported argument, Bussell answered all questions specifically asked in the applications correctly.

the incontestability clauses contained in the Provident policies.[11] Because § 10350.2 empowers insurers to exclude fraudulent misrepresentations from the scope of the incontestability clauses in their policies, and Provident deliberately chose not to do so, Judge Kenyon determined that Provident "cannot challenge any allegedly false or fraudulent statements made by [Bussell] in his application, *even in the guise of a purported unilateral mistake on [Provident's] part. . . . [Provident is] therefore barred, as a matter of law, from disputing statements in [Bussell's] policy applications.*" (App. 45a, emphasis added.) In other words, Provident could not obtain indirectly (via claims for rescission and reformation) that which, as a matter of law, it could not pursue directly (because of the incontestability clauses).

Under *Eichman*, these rulings by Judge Kenyon prohibited the insurers from repeatedly asserting, under the guise of establishing a motive, that Bussell somehow wrongfully obtained multiple policies by supposedly misrepresenting the amount of his income and the existence of other insurance on the applications. Just as the earlier decision in *Eichman* regarding fraudulent concealment as to res judicata impliedly determined the issue of fraudulent concealment concerning the statute of limitations, Judge Kenyon's decisions regarding the effect of Bussell's unlimited insurable interest and the incontestability clauses on the validity of Provident's claims for rescission and reformation impliedly determined the issue of whether the same information could be introduced under the guise of

11. Accordingly, the jury was not shown the evidence from the Medical Information Bureau which revealed that Provident had, in fact, been informed of Bussell's other policies during the two-year contestability period.

establishing a motive. However, the Ninth Circuit totally disregarded the *Eichman* opinion.

The Ninth Circuit also ignored its earlier published opinions with regard to the evidentiary issues raised by Bussell. Thus, the panel determined that evidence of the amount of Bussell's policies (which were purchased over a six year span [RT 866, 875, 877-880]), his pre-disability income levels (which fluctuated due to varying work hours and the number of lower-paying pediatric cases which he agreed to handle [RT 869]), his bankruptcy (filed nearly *three years after* his disability [RT 1839-1840]), his supposed investment losses (the "lost" funds were recouped via litigation [RT 968]) and a resolved tax lien (filed *two years after* his disability [RT 994]) was "relevant to show that [Bussell] had a motive to fake a disability in order to meet his financial obligations." (App. 3a).

However, in its published opinions, the Ninth Circuit has consistently held that, in order for a party's financial condition to be relevant to motive, there has to be some logical nexus between the proffered evidence and a pivotal issue in the case. *See United States v. Feldman*, 788 F.2d 544, 557 (9th Cir. 1986); *United States v. Saniti*, 604 F.2d 603, 604 (9th Cir. 1979). Simply stated, Provident's assertions lacked any logical or temporal nexus.

The sole issue in the first phase of this trial was whether Bussell was "disabled" as that term is defined under the pertinent policies. The only way the financial evidence proffered by the insurers could have "any tendency to make the existence of any fact [i.e., 'fake a disability in order to meet [] financial obligations' [App. 3a] . . . more probable or less probable than it would be without the evidence,"

Federal Rules of Evidence ("FRE") 401, is if the insurers demonstrated that Bussell was unable to meet his financial obligations *at the time he submitted a claim for disability*. In the instant case, *all* of the evidence indicated that, prior to his disability, Bussell had substantial income and assets which were sufficient to meet his financial obligations. (RT 833, 868-873.) Additionally, events which occurred several years after the onset of disability (e.g., the tax lien and bankruptcy) cannot magically and retroactively provide a motive which did not exist at the time of disability. To the contrary, it was the litigation necessitated by the insurers' refusal to honor their policies which caused the financial problems.

Moreover, implicit in the panel's holding is that, as a person with large monthly expenses, Bussell might be more likely to engage in insurance fraud than someone with small monthly expenses. Not only is such a presumption unfair (and evidences the prejudice harbored by the panel), it also contravenes the Ninth Circuit's published case law. In *United States v. Mitchell*, 172 F.3d 1104 (9th Cir. 1999), the Ninth Circuit recently explained why a party's wealth or lack of it, by itself, is legally irrelevant:

> Poverty as proof of motive has in many cases little tendency to make theft more probable. Lack of money gives a person an interest in having more. But so does desire for money, without poverty. A rich man's greed is as much a motive to steal as a poor man's poverty. *Proof of either, without more, is likely to amount to a great deal of unfair prejudice with little probative value.* [¶] There is a distinction between an interest, in the sense that it is in anyone's interest to be richer rather than

> poorer, and an inclination. A mere interest, unconnected with inclination, desperation, or other evidence that the person was likely to commit the crime does not add much, in most cases, to the probability that the defendant committed the crime. If people commonly committed crimes whenever they needed money and could get it by crime, no company would sell life insurance. There is usually a moral disinclination and an interest in avoiding punishment that restrains people from committing crimes out of mere financial interest. The problem with poverty evidence without more to show motive is not just that it is unfair to poor people . . . but that it does not prove much, because almost *everyone, poor or not, has a motive to get more money. And most people, rich or poor, do not steal to get it. Id.* at 1108-1109, emphasis added.

Significantly, the insurers intentionally misrepresented to the District Court, to the jury and to the Ninth Circuit that Bussell's benefits under the policies substantially exceeded his actual income. This was absolutely false. The record is clear that, for a seven month period in 1992, Bussell *actually* earned $300,000. (RT 1116.) Since Bussell was paid based on actual work performed (as opposed to a fixed salary), he received no income for the six weeks of vacation he took in 1992. (RT 1002.) Therefore, this period of time must be excluded from the calculation. Simple math reveals the unassailable fact that $300,000 earned over a five and one-half month period yields an average monthly income of $54,545. Thus, Bussell was actually earning within $500 of the amount for which he was insured (assuming all of the

carriers honored their obligations under the policies, which they did not). Since Bussell's *actual* earnings for the period he *actually* worked in the year of his disability was less than one percent away from the amount for which he was insured, this deviation can in no way be said to be relevant to a motive to fabricate a disability.

Furthermore, if Bussell's desire to increase his wealth, in and of itself, could be relevant to establish his motive to fake an injury, then so too evidence of the insurers' desire to minimize their losses (and thereby maximize their wealth) is relevant to establish their motive to improperly deny a valid claim. In light of the District Court's order bifurcating the issue of disability from the issue of bad faith, the finances of either party were irrelevant to the issue presented by the first phase of the trial, i.e., whether Bussell was disabled as defined by the pertinent policies.

Additionally, in its memorandum decision, the Ninth Circuit upheld the District Court's ruling permitting the insurers to introduce extrinsic evidence (i.e., portions of Bussell's bankruptcy petition) to bolster their claim (which was denied by Bussell) that he had lied on the petition. According to the panel, FRE 608(b) "specifically contemplates inquiries into prior behavior in order to challenge a witness' credibility." (App. 4a). However, the panel's determination is contrary to both the express language of FRE 608(b) ["[s]pecific instances of the conduct of a witness . . . may not be proved by extrinsic evidence"], and *United States v. Higa*, 55 F.3d 448, 452 (9th Cir. 1995), where the Ninth Circuit held: "Where extrinsic evidence is barred, the cross examiner must 'take the answer' [of the witness]. . . ." In other words, if a witness denies having engaged in the alleged misconduct, the disavowed conduct

may not be proved by extrinsic evidence. Not only did the District Court erroneously permit portions of the bankruptcy petition to be admitted, but Bussell's ability to prove that he did not lie on the petition was thwarted by the District Court's order that no extrinsic evidence (other than the petition itself) would be permitted. Bussell was not even permitted to call the actual bankruptcy trustee as a witness.

Finally, for the past 65 years, whenever the Ninth Circuit has been called upon to interpret the incontestability provisions of insurance policies under California law, it has consistently held that an insurer cannot seek to rescind or reform a policy based on misrepresentations contained in the application, even if fraudulent, once the incontestability period has lapsed. *See Paul Revere Life Ins. Co. v. Fima*, 105 F.3d 490, 492 (9th Cir. 1997); *Richardson v. Travelers Ins. Co.*, 171 F.2d 699, 701 (9th Cir. 1948); *Mutual Life Ins. Co. of New York v. Markowitz*, 78 F.2d 396, 398 (9th Cir. 1935).[12]

Bussell was entitled to expect that the Ninth Circuit would abide by its earlier published opinions. The appellate court's failure to do so rendered Bussell's appeal meaningless. Further, this is not an isolated incident. Indeed, in the Final Report of the *Commission on Structural Alternatives for the Federal Courts of Appeal* (December 18, 1998), it was noted that surveys were submitted to district court judges and lawyers in the Ninth Circuit, the "primary consumers of appellate decisions." *Id.* at 39. These surveys

12. The California Supreme Court has also consistently interpreted the incontestability provisions of insurance policies in this manner. *New York Life Ins. Co. v. Hollender*, 38 Cal. 2d 73, 78 (1951); *Coodley v. New York Life Ins. Co.*, 9 Cal. 2d 269, 272 (1937); *Dibble v. Reliance Life Ins. Co.*, 170 Cal. 199, 208 (1915).

revealed that "[d]istrict judges in the Ninth Circuit report finding the law insufficiently clear to give them confidence in their decisions on questions of law about as often as their counterparts in other circuits, but more frequently report that difficulties stem from *inconsistencies between published and unpublished opinions*." *Ibid.*, emphasis added. Lawyers who practice in the Ninth Circuit, "more often than others, reported as a 'large' or 'grave' problem the difficulty in discerning circuit law *due to conflicting precedents*, and the unpredictability of appellate results until the panel's identity is known." *Id.* at 40, emphasis added. Moreover, the Final Report noted that five members of this Court submitted comments to the Commission with specific reference to the Ninth Circuit. Four of these Justices "were of the opinion that it is time for a change. In general, the Justices expressed concern about the ability of judges on the Ninth Circuit Court of Appeals to keep abreast of the court's jurisprudence and the risk of intracircuit conflicts in a court with the output as large as that court's." *Id.* at 38. In addition to these four Justices, "[t]he Chief Justice noted that he 'share[d] many of the concerns expressed by [his] colleagues on the Court who previously corresponded with the Commission and advocated that some change in the structure of the Court of Appeals for the Ninth Circuit is needed.' " *Ibid.*

In response to the Final Report, the Ninth Circuit Court of Appeals has formed an Evaluation Committee which is currently soliciting input from the bench, bar and public concerning inconsistencies between, inter alia, its unpublished memorandum dispositions and its published opinions. (App. G).

It would be one thing if the Ninth Circuit provided a meaningful remedy for litigants who receive an unpublished

memorandum decision which conflicts with the published opinions of the Ninth Circuit. However, as Bussell discovered when he submitted a timely petition for rehearing and suggestion for rehearing en banc, in which he specifically pointed out the conflicts between the unpublished memorandum decision in this action and prior opinions published by the Ninth Circuit, such petitions are routinely and summarily denied. Indeed, according to one treatise, of the 610 petitions for rehearing submitted to the Ninth Circuit in 1997, only 16 were granted. Ulrich, Kessler & Anger P.C., Sidley & Austin, *Federal Appellate Practice: Ninth Circuit*, The Decisionmaking Process, § 8.24, p. 565 (2d ed., West Group, 1999). Moreover, of the 1,092 petitions which suggested a rehearing en banc in 1997, only 19 were granted. *Id.*, Postdecision Proceedings, § 9.14, p. 632.

This petition presents this Court with the opportunity to definitively establish that principles of due process, stare decisis and public policy, including the fairness, stability and predictability that flow from consistent decisions, compel the appellate circuits to follow their own published opinions. This Court should grant the writ both under its supervisory power, Supreme Court Rules, rule 10(a), and because it has never addressed this important federal question which impacts upon every appellate decision rendered, *id.* at rule 10(c).

II.

THE MEMORANDUM DECISION CONFLICTS WITH AN OPINION OF THIS COURT AND VIOLATES THE FIFTH AND TENTH AMENDMENTS

In *Erie R. Co. v. Tompkins*, 304 U.S. 64 (1938), this Court established that a federal court presiding over a diversity action must apply the law of the State:

> Except in matters governed by the Federal Constitution or by Acts of Congress, the law to be applied in any case is the law of the State. And whether the law of the State shall be declared by its Legislature in a statute or by its highest court in a decision is not a matter of federal concern. There is no federal general common law. Congress has no power to declare substantive rules of common law applicable in a State whether they be local in their nature or 'general,' be they commercial law or a part of the law of torts. And no clause in the Constitution purports to confer such a power upon the federal courts.

Id. at 78.

This Court went on in *Erie* to explain why the earlier doctrine that advocated a "general law of the country" which took precedence over a state's own laws was incorrect. Quoting the dissenting opinion of Mr. Justice Field in *B. & O. Railroad v. Baugh*, 149 U.S. 368, 401 (1893), this Court stated:

> . . . [b]ut notwithstanding the great names which may be cited in favor of the doctrine, and notwithstanding the frequency with which the doctrine has been reiterated, there stands, as a perpetual protest against its repetition, the Constitution of the United States, which recognizes and preserves the autonomy and independence of the States — independence in their legislative and independence in their judicial departments. Supervision over either the legislative or the judicial action of the States is in no case permissible except as to matters by the Constitution specifically authorized or delegated to the United States. Any interference with either, except as thus permitted, is an invasion of the authority of the State and, to that extent, a denial of its independence.

Erie, *supra*, 304 U.S. at 78-79.

It is beyond dispute that a state may properly exercise its police power by regulating the insurance industry. *California Auto. Assn. v. Maloney*, 341 U.S. 105, 109 (1951).[13] California's legislature has determined that insurance companies need to be regulated. Accordingly, a comprehensive legislative plan has been adopted governing

13. Indeed, in the McCarran-Ferguson Act, Congress has specifically declared "that the continued regulation . . . by the several States of the business of insurance is in the public interest." 15 U.S.C. § 1011.

the issuance of disability insurance policies and the processing of disability claims. For example, contrary to what the District Court and Ninth Circuit permitted the insurers to tell the jury, there is nothing either illegal or improper about a person ensuring his family's future economic stability in the event of a tragedy by taking out (and paying premiums for) more than one disability policy. This is because the California legislature has determined that there is no such thing as "stockpiling" policies when it comes to one's "own life, health, and bodily safety." § 10110.1(b) ["An individual has an unlimited insurable interest in his or her own life, health, and bodily safety and may lawfully take out a policy of insurance on his or her own life, health, or bodily safety . . . ."] Yet, the insurers were permitted to defy the plain meaning of the California statute and argue to the jury that Bussell must have faked his injury because he purchased multiple policies.

Similarly, § 10350.2 requires insurance companies to include one of two provisions regarding the incontestability of disability claims. Under Form A, an insurance company reserves the right to deny benefits under a disability policy if it later discovers that fraudulent statements were made in conjunction with the application for the policy. However, if an insurance company chooses to include Form B, as the insurers did in the instant case, it cannot deny a claim on the basis of a purportedly fraudulent representation made in conjunction with the application if more than two years has transpired. Clearly, the California legislature has determined that an insurance company must explicitly reserve its right to assert alleged fraud after the incontestability period. This limitation makes sense in a state like California where insurance companies have the ability to easily access all other insurance information during the two-year period. Equally

clear is the choice made by the insurers in the instant case that it is more sound economically to market policies which do not contain such a reservation of rights. However, both the District Court and the Ninth Circuit simply disregarded the import of the incontestability provision, and permitted the insurers to falsely tell the jury that Bussell had lied on the applications.

It violates due process for a federal court to deny a litigant the benefit of applicable state legislation merely because the court disagrees with the wisdom of the legislation. Moreover, it is an unlawful intrusion into the province of a state's domain, and violative of the Tenth Amendment, for a federal court to disregard a legislative plan enacted by a state legislature.[14] *See Olsen v. Nebraska*, 313 U.S. 236, 246 (1941) ["We are not concerned . . . with the wisdom, need, or appropriateness of the legislation. Differences of opinion on that score suggest a choice which 'should be left where . . . it was left by the Constitution — to the States and to Congress.' [Citation.]"]

Accordingly, this Court should grant the writ both under its supervisory power, Supreme Court Rules, rule 10(a), and because the Ninth Circuit has rendered a decision which is contrary to a decision of this Court, as well as the dictates of the Fifth and Tenth Amendments, *id.* at rule 10(c).

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14. At oral argument before the Ninth Circuit, following Bussell's counsel's summary of the various California Insurance Code provisions which pertained to this action and his assertion that the insurers misrepresented the California Insurance Code to the jury, the District Court and the Court of Appeals, Judge Tashima commented: "It doesn't matter what the law on insurance is." Regrettably, Judge Tashima's comment was foretelling of the panel's ultimate refusal to apply the California Insurance Code to the case before it. The audio tape of the oral argument is being lodged concurrently with this petition.

CONCLUSION

For the reasons set forth above, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A — MEMORANDUM OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT DATED AND FILED NOVEMBER 23, 1999

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 98-55546

DC No. CV 94-1756 RAP

PROVIDENT LIFE & ACCIDENT INSURANCE CO., a corp.; JOHN HANCOCK MUTUAL LIFE INSURANCE CO., a corp.,

Plaintiffs-Counter-Defendants-Appellees,

v.

JOHN A. BUSSELL, M.D.,

Defendant-Counter-Claimant-Plaintiff-Appellant,

v.

THE PAUL REVERE LIFE INSURANCE COMPANY, a corp.,

Defendant-Appellee.

MEMORANDUM*

* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by Ninth Cir. R. 36-3.

Appendix A

Appeal from the United States District Court
for the Central District of California
Richard A. Paez, District Judge, Presiding

Argued and Submitted November 3, 1999
Pasadena, California

Before: BROWNING and TASHIMA, Circuit Judges, and KING, District Judge.**

John Bussell appeals the district court's denial of his motion for a new trial on the issue of whether he was "disabled" under the terms of his disability insurance policies. He also appeals the district court's grant of summary adjudication in favor of Provident and John Hancock (together "Provident") on the issues of breach of the covenant of good faith and fair dealing and punitive damages. We affirm both rulings.[1]

A. Motion for a New Trial

We review the district court's denial of a new trial for abuse of discretion. *See Knapp v. Ernst & Whinney*, 90 F.3d

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** Honorable Samuel P. King, Senior United States District Judge for the District of Hawaii, sitting by designation.

1. We decline to address the issue of whether the restitution claim should have been decided by the district court. Bussell is barred from raising this argument here because his conduct in the district court was utterly inconsistent with his current position. *See Marx v. Loral Corp.*, 87 F.3d 1049, 1056 (9th Cir. 1996) (court of appeals deemed equitable estoppel argument waived where party's conduct in the district court was inconsistent with its position on appeal).

1431, 1439 (9th Cir. 1996). Here, substantial evidence supports the jury verdict that Bussell was not disabled as defined by the policies. Several doctors testified that Bussell's claim was subjective, and a reasonable jury could have concluded that he was not telling the truth. There was no abuse of discretion.

1. *Evidentiary Rulings*

Evidence of Bussell's stockpiling of insurance was not barred by law of the case. That doctrine only applies to issues actually decided by the first court. *See United States v. Cote*, 51 F.3d 178, 181 (9th Cir. 1995). Judge Kenyon ruled only that the policies were not void on a theory of overinsurance; he did not consider whether evidence of stockpiling insurance was relevant to Bussell's disability claim.

Furthermore, under Federal Rule of Evidence 401, evidence regarding the amount of insurance Bussell was carrying at the time of his disability — in addition to evidence regarding his pre-disability income, bankruptcy, investment losses and tax obligations — was highly relevant. The insurers' entire theory rested on the premise that Bussell was faking his injury; thus, this evidence was relevant to show that he had a motive to fake a disability in order to meet his financial obligations.[2]

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2. Even assuming that the evidence regarding the $1.2 million tax lien was erroneously admitted, the error was harmless. Over the course of a two week trial, the error would not "more probably than not" have tainted the judgment. *Brown v. Sierra Nev. Mem'l Miners Hosp.*, 849 F.2d 1186, 1190 (9th Cir. 1988) (internal quotation marks and citation omitted).

Federal Rule of Evidence 404(b) also did not prohibit the district court from admitting the evidence of Bussell's finances. Because the evidence was relevant for a reason other than to show that Bussell was predisposed to committing insurance fraud, the district court did not abuse its discretion by admitting the evidence. *See United States v. Hadley*, 918 F.2d 848, 850 (9th Cir. 1990).

The district court did not abuse its discretion in allowing Provident to cross-examine Bussell about alleged misrepresentations on his bankruptcy petition pursuant to Federal Rule of Evidence 608. Evidence that a witness lied on a bankruptcy petition is probative of his character for truthfulness, and Rule 608(b) specifically contemplates inquiries into prior behavior in order to challenge a witness' credibility. *See United States v. Gay*, 967 F.2d 322, 328 (9th Cir. 1992).

The introduction of the surveillance tapes pursuant to Federal Rule of Evidence 1003 also was not an abuse of discretion. Apparently, the trial court credited Mutch's testimony that the copy was a true and correct copy of what was depicted on the original and that the original could not be shown in its current format.

Finally, the district court was not required to exclude the contested evidence under Federal Rule of Evidence 403. The court adequately balanced the probative value against the prejudicial effect of the evidence. There was no abuse of discretion. *See Thurman Indus., Inc. v. Pay 'n Pak Stores, Inc.*, 875 F.2d 1369, 1380 (9th Cir. 1989).

2. *Attorney Misconduct*

The district court did not abuse its discretion in deciding that a new trial was not warranted by attorney misconduct. The improper remarks occurred only during closing argument and the judge admonished the jury that counsel's arguments were not to be considered as evidence. Thus, the misconduct did not permeate the trial so that the jury was necessarily prejudiced or influenced by passion in reaching its verdict. *See Kehr v. Smith Barney, Harris Upham & Co., Inc.*, 736 F.2d 1283, 1286 (9th Cir. 1984).

B. Summary Adjudication

We review a grant of summary judgment *de novo*, *see City of Vernon v. Southern Cal. Edison Co.*, 955 F.2d 1361, 1365 (9th Cir. 1992), and we affirm the district court's grant of summary adjudication on the issue of bad faith. In California, "proper cause" to seek declaratory relief exists as a matter of law if, under an objective standard, "on the basis of the facts known to the [insurer], the institution of the . . . action was legally tenable from the viewpoint of a reasonable attorney." *Dalrymple v. United Servs. Auto. Ass'n*, 46 Cal. Rptr. 2d 845, 857 (Ct. App. 1995).

In the present case, no genuine issue of material fact exists as to whether Provident had "proper cause" to file its claim for declaratory judgment. Contrary to Bussell's arguments, the relevant inquiry is not whether there was a dispute that Bussell was disabled, but rather, whether there was a factual dispute that the insurance company properly brought its suit for declaratory relief. Because of the various

doctors' reports that questioned the validity of Bussell's disability, Provident's counsel had sufficient evidence, from the standpoint of a reasonable attorney, to believe that it had a legally tenable claim.

Even assuming that Bussell is correct that Provident was required reasonably to believe in the validity of each theory it set forth in its declaratory relief action, he still would not prevail. Although Judge Kenyon ultimately ruled against Provident on its alternative theories, it had proper cause to sue under both. Provident presented evidence that it had prior success on both the "lack of insurable interest" and "reformation" theories in other courts, and neither of these theories was foreclosed by appellate law until after Provident filed its declaratory relief claim. Because a "genuine issue as to the insurer's liability" may be created by uncertainties in controlling case law, Provident had an objectively reasonably belief that its alternative causes of action were legally tenable. *Filippo Indus., Inc. v. Sun Ins. Co.*, 88 Cal. Rptr. 2d 881, 887 (Ct. App. 1999). It is not bad faith for an insurer to decline a claim based upon an untested legal theory provided that "intelligent disagreement" on the legal issue was possible. *Clemco Indus. v. Commercial Union Ins. Co.*, 665 F. Supp. 816, 830 (N.D. Cal. 1987).

For the same reasons that Bussell's bad faith claims were properly dismissed, punitive damages are not recoverable. *See Continental Ins. Co. v. Superior Court*, 43 Cal. Rptr. 2d 374, 384 (Ct. App. 1995).

AFFIRMED.

APPENDIX B — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA DENYING JOHN A. BUSSELL M.D.'S MOTION FOR A NEW TRIAL DATED AND FILED FEBRUARY 4, 1998 AND ENTERED FEBRUARY 5, 1998

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CASE NO. CV94-1756 RAP (EEx)

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY, a corporation; And JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY, a corporation,

Plaintiffs,

v.

JOHN A. BUSSELL, M.D.,

Defendant.

Appendix B

JOHN A. BUSSELL, M.D.,

Counter-Claimant,

vs.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY, a corporation; and JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY, a corporation,

Counter-Defendants.

CASE NO. CV94-5987 RAP (Kx)

JOHN A. BUSSELL,

Plaintiff,

vs.

THE PAUL REVERE LIFE INSURANCE COMPANY, a corporation, and DOES 1 Through 100, Inclusive,

Defendants.

ORDER DENYING JOHN A. BUSSELL M.D.'S MOTION FOR NEW TRIAL

On February 2, 1998, at 9:30 a.m., the motion for new trial filed by defendant, counterclaimant and plaintiff JOHN A. BUSSELL, M.D. came on regularly for hearing before the Honorable Richard A. Paez in Courtroom 750 of the

above-entitled court. Larry R. Feldman and Joel N. Klevens appeared on behalf of Dr. BUSSELL, Melissa M. Cowan appeared on behalf of plaintiffs and counterdefendants PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY and JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY, and Edwin A. Oster appeared on behalf of defendant THE PAUL REVERE LIFE INSURANCE COMPANY.

After reviewing the papers filed by the parties in support of and in opposition to the motion, and after reviewing those necessary portions of the court file, reviewing applicable law, and listening to argument of counsel, the court hereby orders that Dr. BUSSELL's motion for new trial is denied in its entirety.

IT IS SO ORDERED.

DATED: February 4, 1998

s/ RICHARD A. PAEZ
RICHARD A. PAEZ
UNITED STATES DISTRICT
COURT JUDGE

APPENDIX C — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA GRANTING MOTIONS FOR SUMMARY ADJUDICATION OF PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY AND JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY AND DENYING MOTION FOR SUMMARY ADJUDICATION OF PAUL REVERE LIFE INSURANCE COMPANY DATED AND FILED JUNE 27, 1996 AND ENTERED JUNE 28, 1996

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CASE NO. CV-94-1756-RAP

CONSOLIDATED WITH
CASE NO. CV-94-5987-RAP

PROVIDENT LIFE AND ACCIDENT
INSURANCE COMPANY, et al.,

Plaintiffs,

v.

JOHN A. BUSSELL, M.D.,

Defendant.

AND RELATED COUNTERCLAIMS

Appendix C

JOHN A. BUSSELL, M.D.,

Plaintiff,

v.

PAUL REVERE LIFE INSURANCE COMPANY,

Defendant.

ORDER GRANTING MOTIONS FOR SUMMARY ADJUDICATION OF PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY AND JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY AND DENYING MOTION FOR SUMMARY ADJUDICATION OF PAUL REVERE LIFE INSURANCE COMPANY

On May 16, 1996, the Court heard the motions for summary adjudication in two consolidated insurance bad faith actions. The motions were brought by counter-defendants Provident Life and Accident Insurance Company ("Provident") and John Hancock Mutual Life Insurance Company ("Hancock"); and by defendant, The Paul Revere Life Insurance Company ("Paul Revere"). Upon full consideration of the moving, opposition, and reply papers, exhibits, declarations, authorities, and arguments of counsel, the Court hereby GRANTS the motions of Provident and Hancock. The Court hereby DENIES the motion of Paul Revere.

Appendix C

I

Introduction

Insurers Provident and Hancock filed an action for declaratory relief against John A. Bussell, M.D., to determine their liability under disability insurance policies they issued to Dr. Bussell. Dr. Bussell counterclaimed against these insurers. Dr. Bussell also brought a separate action against a third insurer, Paul Revere, alleging it wrongfully denied him coverage under a disability insurance policy. Since these cases involve similar claims, they have been consolidated for pre-trial purposes. Dr. Bussell alleges claims for breach of contract and breach of the covenant of good faith and fair dealing against Provident, Hancock, and Paul Revere and seeks compensatory and punitive damages.

In its motion for summary adjudication, Paul Revere argues that the federal Employee Retirement and Insurance Savings Act ("ERISA"), preempts the state law causes of action against it since it issued its disability insurance policy pursuant to an employee welfare benefit plan governed by ERISA. Paul Revere also argues that there is no evidence which would support an award of punitive damages.

Provident has filed two separate motions, both seeking summary adjudication on certain of the counterclaims.[1] First, it maintains that it had proper cause to file its action for declaratory relief given the facts known to it and the state of

1. Unless otherwise noted, when the Court refers to Provident, it also refers to Hancock. These two insurance companies brought their motions together.

California law at that time. In light of this proper cause, it seeks a ruling from the Court holding that its filing of the declaratory relief action against Dr. Bussell cannot be used as evidence of bad faith. Second, Provident argues that plaintiff has no evidence to support its claim for punitive damages.

II

Relevant Facts

A. *The Paul Revere Policy*

On or about June 1, 1992, Paul Revere issued to General Anesthesiology Specialists ("GAS") a group insurance policy providing for the payment of long-term disability benefits. Paul Revere's Statement of Uncontroverted Facts ("Statement"), ¶ 1.[2] A copy of the policy is attached as Exhibit 1 to the Declaration of Robert K. Renner. Formed in 1991, GAS was a general partnership having two general partners, Drs. Ronald Wender and Julian Gold. Statement, ¶ 4. Paul Revere's disability insurance policy had been purchased for the benefit of the members of a group, comprised of GAS and its member anesthesiologists, "glued" together by a contract and subcontract. Statement, ¶ 10.

Plaintiff was one of these anesthesiologists. Plaintiff sets forth substantial evidence to show that the member anesthesiologists were independent contractors, and not

2. The Court only cites to Paul Revere's Statement of Uncontroverted Facts where there is no factual dispute raised by the parties.

GAS' employees. See Plaintiff's Statement of Genuine Issues in Opposition to the Statement, ¶¶ 3-13, pp. 9-15. Plaintiff claimed a disability arising from an accident, and applied for benefits under the disability insurance policy. Paul Revere denied plaintiff's application for disability benefits. Motion of Paul Revere at 4.

B. *Paul Revere's Treatment of Dr. Bussell's Claim*

Dr. Bussell alleges that he suffered a disabling back injury which prevents him from performing his work as a cardiac anesthesiologist. Paul Revere's claim examiner, Jean Mantolesky, testified that her superiors ordered a "thorough review" of the Bussell claim. Len Cavallaro, the regional group sales director for GAS, indicated that GAS did not want the claim paid. Mantolesky Deposition at 30-39.[3]

Dr. Bussell also refers the Court's attention to the testimony of Ms. Buckley, the person at Paul Revere chiefly responsible for the handling of Dr. Bussell's claim. Buckley admitted that Dr. Bussell had serious back pain symptoms.

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3. Paul Revere points to later deposition testimony given by Mantolesky where she says that employers (in this case GAS) will frequently give "input" of this nature, but that such input did not constitute "instructions." As to the order to do a "thorough review" that her superiors gave her, Mantolesky explains that they always wanted her to do a thorough review. Mantolesky Deposition at 31, 37. Paul Revere maintains that the combination of the GAS' "input" and Mantolesky's superiors' instructions were nothing out of the ordinary. This may be true. However, the same facts could also support Bussell's view that Paul Revere immediately embarked upon a campaign to unreasonably deny Bussell coverage under Paul Revere's insurance policy.

Buckley Declaration, ¶ 1. Buckley also did not know if Dr. Bussell could safely perform his job as a cardiac anesthesiologist in "life and death situations." Buckley Deposition at 53-62, 186. Dr. Bussell asserts that this testimony will support a reasonable inference that Paul Revere decided to unreasonably deny Dr. Bussell's claim.[4]

Dr. Bussell also claims that Paul Revere relied on doctors who did not have expertise in diagnosing or treating spinal injuries. Opposition at 6-7. Buckley Deposition at 146-54; and Exhibits 3, 4, & 5 attached to Paul Revere's Motion.[5] Dr. Bussell then presents evidence to show that Paul Revere did not rely upon the opinions of several doctors, who either concluded that Dr. Bussell did suffer from a disabling spinal injury or indicated that more medical evaluation was needed. See Buckley Deposition at 180-81, 187-89, 193-94, 238,

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4. Paul Revere maintains that Buckley's testimony is not relevant since her job duties did not include evaluating Bussell's medical condition. However, the admission that the chief handler of Bussell's claim did not understand the medical significance of Bussell's alleged condition raises more questions than it answers. The evidence could support the inference that Paul Revere's failure in this regard constituted an intentional decision to not properly investigate his claim and to instead unreasonably deny it.

5. Paul Revere does not dispute that certain doctors on which it relied were not expert in the diagnosis or treatment of spinal injuries. The parties do disagree on the inferences to be drawn from that fact, however. Paul Revere contends that although some of the doctors it utilized were not specialists, they were all adequate. For purposes of summary judgment, however, all inferences are to be drawn in favor of non-movant, Bussell.

240-42; Bussell Declaration, Exhibits O, P, S, and T.[6] Dr. Bussell then points to Paul Revere's investigation of the backgrounds of *only* those doctors who gave favorable reports to Dr. Bussell. Buckley Deposition at 258-60; Exhibit U.[7]

C. *Provident's Treatment of Dr. Bussell's Claim*

After Dr. Bussell made his claims to Provident and Hancock, both proceeded to pay Dr. Bussell his policy benefits. Ed Ruiz was the decision maker for both the Provident and Hancock policies.[8] Ruiz alerted Dr. Bussell to the fact that the total monthly benefits under all of his disability insurance polices exceeded Provident's $15,000 per month internal "participation limit." Ruiz asserted that the policy was void if Dr. Bussell could not establish that his monthly income exceeded his disability benefits for all

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6. Paul Revere maintains that it did not ignore any medical opinions, but merely did not have enough evidence to conclude that Bussell was totally disabled. Paul Revere claims that Bussell failed to cooperate so that it could not make a further determination.

7. Paul Revere maintains that Buckley did not order the investigation of the other doctors since that was not her responsibility. There is no dispute that the investigation of these doctors was ordered. Although there may not be anything sinister about the investigations, that factual dispute cannot be resolved on a motion for summary adjudication.

8. Provident became responsible for certain policies issued by Hancock, one of which was the disability policy issued to Dr. Bussell. Ruiz "was personally involved with the decision made to file [suit] on behalf of both Provident and [Hancock]." Declaration of Edwin Ruiz, ¶¶ 2, 4.

the policies. Bussell Declaration, ¶ 17; Exhibits X, L; Ruiz Deposition at 235-41, 476. Ruiz offered Dr. Bussell two months worth of benefits if he would surrender the Hancock and Provident policies. *Id.*

Dr. Bussell points to an internal memorandum authored by Ruiz which suggests that he knew these defenses were not valid because of the incontestability clauses in the policies. Exhibits X, L; Ruiz Deposition at 132-33. Hancock stopped payment to Dr. Bussell for a few months, but later resumed making payments. Exhibit J.

Hancock and Provident filed their declaratory relief action on three grounds: (1) Dr. Bussell lacked an insurable interest; (2) Dr. Bussell made allegedly false statements about his income and retention of other disability policies; and (3) Dr. Bussell was not disabled within the meaning of the policies. Judge Kenyon dismissed the claim that Dr. Bussell did not have an insurable interest, stating that a person has an unlimited insurable interest in his own health pursuant to California Insurance Code section 11010.1(b). Judge Kenyon also dismissed the claims concerning Dr. Bussell's alleged misrepresentations about income and insurance coverage because of the incontestability clauses in the policies. The only remaining claim is that Dr. Bussell is not disabled within the meaning of Provident's disability policies.

Dr. Bussell filed for Chapter 7 Bankruptcy on March 7, 1995. Provident and Hancock ceased making payments to Dr. Bussell on the grounds that he would not have assets or income to pay any judgment they might obtain in their declaratory relief action. Exhibit K.

Appendix C

IV

Standard

Rule 56(c) of the Federal Rules of Civil Procedure provides for summary judgment if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." In a trilogy of 1986 cases, the Supreme Court clarified the standard for summary judgment. *See Celotex Corporation v. Catrett*, 477 U.S. 317 (1986); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986); *Matsushita Electrical Industry Co. v. Zenith Radio Corp.*, 475 U.S. 574 (1986).

The moving party bears the initial burden of demonstrating the absence of a genuine issue of material fact for trial. *Anderson*, 477 U.S. at 256. Whether a fact is material is determined by looking to the governing substantive law; if the fact may affect the outcome it is material. *Id.* at 248. When the non-moving party bears the burden of proving the claim or defense, the moving party can meet its burden by pointing out the absence of evidence from the non-moving party. The moving party need not disprove the other party's case. *See Celotex*, 477 U.S. at 325; *see also* Schwarzer, Tashima & Wagstaffe, Federal Civil Procedure Before Trial §§ 14:123-141 (1993).

When the moving party meets its burden, the "adverse party may not rest upon the mere allegations or denials of the adverse party's pleadings, but the adverse party's

response, by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial." Fed.R.Civ.P. 56(e).

In assessing whether the non-moving party has raised a genuine issue, its evidence is to be believed, and all justifiable inferences are to be drawn in its favor. *Anderson*, 477 U.S. at 255 (citing *Adickes v. S. H. Kress and Company*, 398 U.S. 144 (1970)). Nonetheless, "the mere existence of a scintilla of evidence" is insufficient. *Id.* at 252. As the Court explained in *Matsushita*, 475 U.S. at 586-87:

> When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show that there is some metaphysical doubt as to the material facts . . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no "genuine issue for trial."

In evaluating the evidence presented by the opposing party, the standard to be used is the one that party must meet at trial. *Anderson*, 477 U.S. at 252. For a preponderance of the evidence standard, the opposing party's evidence need only be such that "a fair-minded jury could return a verdict for the (opposing party) on the evidence presented. *Id.*

Appendix C

V

Analysis

A. *Paul Revere's Claim of ERISA Preemption*

Paul Revere first argues that Dr. Bussell cannot maintain his state law causes of action since they are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. Paul Revere claims that the disability policy it issued to Dr. Bussell was an "employee benefit plan" under ERISA. 29 U.S.C. § 1003(a). An employee benefit plan is defined as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan." 29 U.S.C. § 1002(3). The Paul Revere policy could only be classified as an employee welfare benefit plan.

Plans without employees are not "employee benefit plans." 29 CFR § 2510.3-3(b).

> Plans without employees. For purposes of Title I of [ERISA] and this chapter, the term "employee benefit plan" shall not include any plan, fund or program, other than an apprenticeship or other training program, under which no employees are participants covered under the plan, as defined in paragraph (d) of this section. For example, a so called "Keough" or "H.R. 10" plan under which one or more common law employees, in addition to the self-employed individuals, are participants

> covered under the plan, will be covered under Title I . . .

29 C.F.R. § 2510.3-3(b) (1990).

A plan whose participants are not employees cannot be an ERISA plan. *Kennedy v. Allied Mutual Insurance Co.*, 952 F.2d 262, 264 (9th Cir. 1991) ("As a result, a plan whose sole beneficiaries are the company's owners cannot qualify as a plan under ERISA.") Dr. Bussell maintains that he was never an employee of GAS but was an independent contractor. If that is the case, then no "employee benefit plan" exists under ERISA and there can be no ERISA preemption.

In *Nationwide Mutual Insurance Company v. Darden*, 503 U.S. 318, 112 S.Ct. 1344 (1992), the Supreme Court held that courts must use common law agency doctrine to decide whether or not a plan participant was an employee or an independent contractor.

> The traditional common-law criteria that courts have employed include: 1) the degree of control and supervision over the manner in which the work is performed; 2) whether or not the "employee" is engaged in his own business; 3) the company's right to hire and discharge the persons doing the work; 4) the method of compensation to the "employee"; 5) whether the "employee receives the same benefits as the company's regular employees; 6) who has control of the premises where the work is done; 7) how the parties structure their Social Security and

> income relations; 8) whether the "employee" stands to make a profit on the work of those working for him; 9) the amount of the "employee's" investment in facilities and equipment; 10) the belief of the parties as to their business relationship; 11) the amount of skill required in the particular occupation; and 12) the duration of time for which the "employee" is employed.

Wolcott v. Nationwide Mutual Insurance Company, 884 F.2d 245, 251 (6th Cir. 1989).

"The existence of an ERISA plan is a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person." *Harper v. American Chambers Life Insurance Company*, 898 F.2d 1432, 1433 (9th Cir. 1990) (citing to *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988), *cert. denied*, 109 S.Ct. 3216, 106 L.Ed. 2d 566 (1989)).

Paul Revere argues that whether or not Dr. Bussell is an employee is irrelevant to deciding whether or not an ERISA plan exists. It cites to a line of cases, the most important of which is *Qualls v. Blue Cross of California, Inc.* 22 F.3d 839, 843 (9th Cir. 1994). There, the Ninth Circuit held that only under limited circumstances is an employer's involvement in a group insurance plan not significant enough to constitute a "plan." Under the "safe harbor" provisions of the Department of Labor, the following four requirements must be met for a "plan" to be excluded from ERISA:

(1) the employer makes no contributions; (2) the participation by employees is completely voluntary; (3) the employer does not endorse the program and his sole functions are to promote the program to employees and to collect premiums through dues or payroll deductions and to remit them to the insurance company; and (4) no consideration is received by the employer for this limited involvement. *Id. See also* 29 U.S.C. § 1002(1); 29 C.F.R. § 2510.3-1(j). A plan will be exempted under ERISA only if all of the above conditions are met.

Paul Revere fails to recognize that *Qualls* involved an ERISA plan where the plan clearly applied to employees of defendant employer in that case. The other cases cited by Paul Revere are also distinguishable on this ground. *Peterson v. American Life & Health Ins. Co.*, 48 F.3d 404, 407-08 (9th Cir. 1995) (ERISA benefit plan, which was composed of more than one policy, covered employees); *Harper v. American Chambers Life Insurance Co.*, 898 F.2d 1432 (9th Cir. 1990) (reversing district court's ruling that a plan was an ERISA plan since district court did not make findings as to whether or not the various policies covered employees); *Bellisario v. Lone Star Life Insurance*, 871 F. Supp. 374, 377 (C.D. Cal. 1994) (the court first established that the plan had employees before applying the safe harbor exemption from ERISA found in 29 U.S.C. § 1002(1) and 29 C.F.R. § 2510.3-1(J)). The cases do *not* state that the distinction between independent contractor and employee is inconsequential.

In the present case, Paul Revere presented no evidence that its disability insurance policy applied to any employees. Accordingly, there can be no ERISA preemption.

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In the alternative, defendants argue that even if coverage of employees is a mandatory element of an ERISA plan, plaintiff is a common law employee. Reply at 5-6. The proffered evidence strongly suggests that there is no disputed material fact to preclude the Court from concluding that Dr. Bussell was not an employee but rather an independent contractor. Therefore, the Court must deny Paul Revere's motion for summary adjudication on the issue of whether Dr. Bussell's state claims are preempted by ERISA. In an abundance of caution, the Court will not *sua sponte* declare that Dr. Bussell was an independent contractor since Dr. Bussell has not yet established that he is entitled to summary adjudication on this point as a matter of law. The Court must deny Paul Revere's motion for summary adjudication based on ERISA preemption.

B. *Punitive Damages against Paul Revere*

Punitive damages are awardable for actions not arising from contract.

> In an action for the breach of an obligation not arising from contract, where it is proven by clear and convincing evidence that the defendant has been guilty of oppression, fraud, or malice, the plaintiff, in addition to the actual damages, may recover damages for the sake of example and by way of punishing defendant.
>
> . . .
>
> (1) "Malice" means conduct which is intended to by the defendant to cause injury to the plaintiff

> or despicable conduct which is carried on by the defendant with a willful and conscious disregard of the rights or safety of others.
>
> "Oppression" means despicable conduct that subjects a person to cruel and unusual hardship in conscious disregard of that person's rights.
>
> "Fraud" means an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury."

California Civil Code sections 3294(a), (c).

"In order to establish that an insurer's conduct has gone sufficiently beyond mere bad faith to warrant a punitive award, it must be shown by clear and convincing evidence that the insurer has acted maliciously, oppressively or fraudulently." *Mock v. Michigan Millers Mutual Insurance Company*, 4 Cal.App.4th 306, 328, 5 Cal.Rptr.2d 594, 607 (1992).

California courts have ruled on the question of what is and is not malicious or oppressive conduct, punishable with punitive damages. In *College Hospital, Inc., v. Superior Court*, 8 Cal.4th 704, 34 Cal.Rptr.2d 898 (1994), plaintiff psychiatric patient sued a hospital for damages she suffered for the alleged actions of the hospital's employee who purportedly lured her into an extramarital affair. The

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California Supreme Court held that plaintiff could not seek punitive damages against the hospital, in part, because the alleged behavior by the hospital administrator would not support an award of punitive damages.

Plaintiff alleged in her complaint that the hospital manager heard a rumor about the hospital employee's affair with plaintiff. The hospital manager then confronted the employee with the rumor, which the hospital employee denied. The hospital manager made known that the rumored behavior was unacceptable, but took no further action. *Id.* at 725, 911. Plaintiff argued that the hospital manager acted with malice since "any personal contact between a therapy patient and a hospital employee is presumptively harmful and that [the hospital manager's] acceptance of [the hospital employee's] denial without further investigation was inherently malicious." *Id.*

The California Supreme Court ruled that the above allegations could not serve as a basis for the award of punitive damages. There were no allegations or evidence to show that the hospital administrator knew that the relationship was sexual or destructive; that the hospital employee had been involved in a previous relationship with a patient; or that the hospital employee lied when he denied the rumor of his relationship with plaintiff. Id. at 726, 911. "As a result, plaintiffs have necessarily failed to state or demonstrate that [the hospital administrator] intended to injure plaintiffs or willfully disregarded their safety and well-being by accepting [the hospital employee's] denial." *Id.*

In *Tomaselli v. Transamerica Insurance Company*, 25 Cal.App.4th 1269, 31 Cal.Rptr.2d 433 (1994), plaintiff

homeowners sued defendant insurer for failure to pay benefits under the homeowners' insurance policy. The jury awarded plaintiffs contract, tort, and punitive damages. The appeals court reversed the jury's award of punitive damages, holding, in part, that the evidence was inadequate to support a finding of punitive damages.

The evidence at trial supported the inference that the defendant insurer used outside counsel and certain investigative procedures in an overzealous attempt to unearth reasons to deny coverage. The evidence also supported the inference that the insurer negligently failed to investigate information provided by plaintiff that could support a finding of coverage, and that the insurer callously failed to communicate with the insureds. Finally, the evidence also showed that the insurance company negligently relied upon an endorsement to deny coverage that had never been delivered to plaintiffs. Despite this conduct, the California Supreme Court held that an insurer's overzealousness, negligence, callousness, and legal error are not sufficient grounds under California law to support an award for punitive damages. *Id.* at 1288, 445.

In *Mock v. Michigan Millers Mutual Insurance Company*, 4 Cal.App.4th 306, 328, 5 Cal.Rptr.2d 594, 607 (1992), plaintiff homeowners sued for benefits arising under their homeowners' insurance policy. Plaintiffs sued for damages caused to their property resulting from construction and maintenance of storm drains by the City of Palo Verdes ("City"). The City's alleged negligence caused earth movement which allegedly decreased the property damage of plaintiffs' home. *Id.* at 314, 597. Defendant insurer agreed

that coverage existed, but delayed payment of plaintiff's claim for two reasons: (1) the insurer wanted to obtain documentation of any geological damage to plaintiff's property so it could preserve its subrogation claim against the City, and (2) the insurer conditioned payment of the claim on plaintiffs assigning their right of recovery against the City to the insurer. *Id.* at 318-20, 600-02. The appeals court found that this evidence supported the jury verdict that the insurer acted in bad faith in delaying payment of policy benefits. *Id.* at 324, 605.

The court reversed the jury's award of punitive damages for plaintiffs', due to the trial court's instructional error. However, based on the evidence before the trial court, the appeals court concluded that "reasonable minds could differ" on the question of punitive damages. *Id.* at 338, 614. The insurer's desire to protect its subrogation rights and its request for the assignment from plaintiffs could be characterized as despicable conduct. The *Mock* court remanded the case to the trial court for a new trial on the question of punitive damages. *Id.* at 339, 615.

In the present action, Dr. Bussell has presented evidence to the Court from which a reasonable trier of fact could conclude that Paul Revere engaged in a *willful* campaign to ignore medical evidence that would support a finding of disability and the payment of bene[illegible] as provided in the policy. Furthermore, Dr. Bussell marshalls evidence to suggest that Paul Revere decided to deny coverage *before* conducting its investigation of Dr. Bussell's claim. This may present a situation far different from the overzealousness, negligence, and callousness committed by the insurer in

Tomaselli. The willful disregard of an insured's rights can potentially support a punitive damages award. Accordingly, the Court finds there is a material triable issue of fact and Paul Revere's Motion for Summary Adjudication must be denied.

The Court arrives at this conclusion after drawing all reasonable inferences in favor of Dr. Bussell, which it must on a motion for summary adjudication. At time of trial, however, a reasonable trier of fact might well conclude that the evidence is insufficient to support an award of punitive damages.

C. *The Bad Faith Claim Against Provident*

Denial of a claim does not in and of itself constitute bad faith. The insurer must have withheld benefits under the policy unreasonably. "The mistaken witholding of policy benefits, if reasonable or if based on a legitimate dispute as to the insurer's liability under California law, does not expose the insurer to bad faith liability." *Tomaselli v. Transamerica Insurance Company*, 25 Cal.App.4th 1269, 1280-81, 31 Cal.Rptr.2d 433, 440 (1994).

A recent California appellate case, *Dalrymple v. United Services Automobile Association*, 40 Cal.App.4th 497, 46 Cal.Rptr.2d 845 (1995), sets forth the standard in California for deciding when initiating an action for declaratory relief constitutes bad faith. In *Dalrymple*, the insured had a renter's policy which provided for personal liability coverage. The insured suffered from mental problems, and during an episode of mental instability, shot a police officer attempting

to take her into custody while she was in her home. In her delusional state, the insured thought the police officer was an intruder who intended to harm her. *Id.* at 504-05; 847-49. The police officer filed an action for damages against the insured. *Id.*

The insured's renter's policies only extended coverage for an "occurrence" which was an "accident." The insurer contended that no coverage existed here since the insured's shooting of the officer was an intentional act. *Id.* at 518, 856. In evaluating whether the insurer's declaratory relief action was instituted in bad faith, the *Dalrymple* court used an objective standard. "[T]he Court determines whether, on the basis of the facts known to the [insurer], the institution of the prior action was legally tenable from the viewpoint of a reasonable attorney." *Id.* at 519, 857 (citation omitted).

At the time the insurer in *Dalrymple* instituted the declaratory relief action, recent decisions in the California appellate courts supported the insurer's position. The *Dalrymple* court acknowledged that the law interpreting the terms "occurrence" and "accident" was "still developing." *Id.* at 522, 859. Thus, the court held that there could be no bad faith liability for instituting the declaratory relief action since the insurer had proper cause for filing the suit.

In the present action, it is undisputed that evidence exists to support both Provident and Dr. Bussell on the issue of Dr. Bussell's disability. This presents a serious factual dispute. Provident's declaratory relief action was not instituted in bad faith since Provident had, and continues to

have proper cause to seek a judicial determination of this question.[9]

Dr. Bussell argues that other actions taken by Provident are evidence of bad faith, and preclude the Court from granting Provident's motion. He points to Provident's offer to give Dr. Bussell two months worth of benefits to settle their dispute about the policy. Dr. Bussell also asserts that Provident's decision to stop paying policy benefits after he declared Chapter 7 bankruptcy was in bad faith.

Neither of these actions, however, constituted bad faith in light of Provident's legitimate basis for bringing the declaratory relief action to resolve the question of Dr. Bussell's disability. Since there was proper cause to bring the action for declaratory relief, Provident also had proper cause to make settlement offers to Dr. Bussell and to stop payment of Dr. Bussell's policy benefits pending resolution of Provident's suit. Dr. Bussell does not argue that the delay

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9. The Court need not decide whether Provident had proper cause to bring the other claims which Judge Kenyon dismissed since Provident had proper cause to seek a judicial declaration of whether Bussell was disabled within the meaning of the policy. Obviously, if Provident can withhold benefits on the grounds that Bussell is not disabled, it is irrelevant if Provident alleged other meritless claims in its declaratory relief action.

Nor does it matter if Provident really did not rely on the issue of disability, but instead brought the declaratory relief action primarily on the claims dismissed by Judge Kenyon. The subjective intent of the insurer is irrelevant. Proper cause is judged under an objective standard. *Dalrymple*, 40 Cal.App.4th at 517, 46 Cal.Rptr.2d at 856.

in paying the benefits under the Provident policy caused him any damages, apart from not receiving those benefits.

On the present record, no reasonable trier of fact could conclude that Provident committed any action, including terminating benefits to Dr. Bussell, that constituted bad faith. Accordingly, Provident's motion for summary adjudication of the counterclaim is granted.[10]

VI

Conclusion

For the reasons set forth above, Paul Revere's Motion for Summary Adjudication is DENIED. The Motions for Summary Adjudication of Provident and Hancock are GRANTED.

IT IS SO ORDERED.

DATED: June 26, 1996

s/ Richard A. Paez
Hon. Richard A. Paez
United States District Judge

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10. It necessarily follows that Dr. Bussell no longer has a basis for a claim of punitive damages against Provident or Hancock.

APPENDIX D — JUDGMENT ON SPECIAL VERDICT OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA DATED DECEMBER 9, 1997 AND ENTERED DECEMBER 11, 1997

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The Paul Revere Life Insurance Company

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CASE NO. CV 94-1756 RAP(RNBx)

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY, a corporation; and JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY, a corporation,

Plaintiffs,

v.

JOHN A. BUSSELL, M.D.,

Defendant.

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JOHN A. BUSSELL, M.D.,

Counterclaimant,

v.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY, a corporation; and JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY, a corporation,

Counterdefendants.

CASE NO. CV 94-5987 RAP(RNBx)

JOHN A. BUSSELL,

Plaintiff,

v.

THE PAUL REVERE LIFE INSURANCE COMPANY, a corporation, and DOES 1 through 50, inclusive,

Defendants.

JUDGMENT ON SPECIAL VERDICT

These consolidated actions came on regularly for trial commencing October 7, 1997 in Courtroom 750 of the United States District Court, Central District, the Honorable Richard A. Paez, Judge presiding.

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Relative to Case Number 94-1756 RAP(RNBx), Plaintiffs/Counterdefendants **Provident Life and Accident Insurance Company** and **John Hancock Mutual Life Insurance Company** appeared by and through their attorneys David A. Lingenbrink and Melissa M. Cowan of the law firm of Galton & Helm, 500 South Grand Avenue, Suite 1200, Los Angeles, California 90071-2609, and Defendant/Counterclaimant **John A. Bussell, M.D.** appeared in person and by and through his attorneys Larry R. Feldman and Joel N. Klevens of the law firm of Fogel, Feldman, Ostrov, Ringler & Klevens, 1620 26th Street, Suite 100 South, Santa Monica, California, 90404-4040.

Relative to Case Number 94-5987 RAP(RNBx), Plaintiff **John A. Bussell, M.D.** appeared in person and by and through his attorneys Larry R. Feldman and Joel N. Klevens of the law firm of Fogel, Feldman, Ostrov, Ringler & Klevens, 1620 26th Street, Suite 100 South, Santa Monica, California, 90404-4040, and Defendant **The Paul Revere Life Insurance Company** appeared by and through its attorneys Edwin A. Oster and Robert K. Renner of the law firm of Barger & Wolen LLP, 19800 MacArthur Boulevard, Suite 800, Irvine, California, 92612-2427.

A jury of nine persons was regularly empaneled and sworn. Witnesses were sworn and testified. After hearing the evidence and arguments of counsel, the jury was duly instructed by the Court and the cause was submitted to the jury with directions to return a verdict on special issues. The jury deliberated and thereafter returned to Court on November 7, 1997 with its verdict consisting of the special issues submitted to the jury and the answers given thereto

by the jury, which verdict was in words and figures as follows, to wit:

We, the jury in the matters of John A. Bussell, M.D., Provident Life and Accident Insurance Company, John Hancock Mutual Life Insurance Company and The Paul Revere Life Insurance Company cases, find the following special verdict on the questions submitted to us:

Question No. 1:

Do you find that Dr. Bussell has proven by a preponderance of the evidence that he has been totally disabled from his occupation for each month he claims to have been so disabled?

Yes: ____

No: *X

If your answer is "yes," go to Question Nos. 2, 3 and 4. If your answer is no, sign and date this form.

* * *

Dated: November 7, 1997 s/ Ruth Hereford
JURY FOREPERSON

By reason of said special verdict and good causes appearing, Judgment shall be entered in favor of Plaintiffs/ Counterdefendants **Provident Life and Accident Insurance Company** and **John Hancock Mutual Life Insurance**

Company and against Defendant/Counterclaimant **John A. Bussell, M.D.** in Case Number CV 94-1756 RAP(RNBx).

By reason of said special verdict and good causes appearing, Judgment shall be entered in favor of Defendant **The Paul Revere Life Insurance Company** and against Plaintiff **John A. Bussell, M.D.** in Case Number CV 94-5987 RAP(RNBx).

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that Plaintiffs/Counterdefendants **Provident Life and Accident Insurance Company** and **John Hancock Mutual Life Insurance Company** are entitled to Judgment on the Counterclaim filed by Defendant/Counterclaimant **John A. Bussell, M.D.**, that the claim for declaratory relief filed by Plaintiffs/Counterdefendants **Provident Life and Accident Insurance Company** and **John Hancock Mutual Life Insurance Company** is rendered moot, that the claim for restitution filed by Plaintiffs/Counterdefendants **Provident Life and Accident Insurance Company** and **John Hancock Mutual Life Insurance Company** is dismissed without prejudice to Plaintiffs/Counterdefendants rights in United States Bankruptcy Court, Central District of California, Adversary Proceeding Number AD 95-02723 TD [entitled *Provident Life and Accident Insurance Company and John Hancock Mutual Life Insurance Company v. John A. Bussell*], and that Plaintiffs/Counterdefendants **Provident Life and Accident Insurance Company** and **John Hancock Mutual Life Insurance Company**, as prevailing parties, are entitled to recover their costs and disbursements from Defendant/Counterclaimant **John A. Bussell, M.D.**

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IT IS HEREBY ORDERED, ADJUDGED AND DECREED that Plaintiff **John A. Bussell, M.D.** shall recover nothing by way of his complaint and that Defendant **The Paul Revere Life Insurance Company**, the prevailing party, is entitled to recover its costs and disbursements from Plaintiff **John A. Bussell, M.D.**

DATED: Dec. 9, 1997

s/ Richard A. Paez
JUDGE RICHARD A. PAEZ
UNITED STATES DISTRICT COURT

APPENDIX E — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA GRANTING MOTION TO DISMISS AND MOTION TO STRIKE DATED AND FILED JUNE 10, 1994 AND ENTERED JUNE 14, 1994

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CV 94-1756 KN (EEx)

PROVIDENT LIFE AND ACCIDENT INS. CO., *et al.*,

Plaintiffs,

v.

JOHN A. BUSSELL, M.D.

Defendant.

ORDER GRANTING MOTION TO DISMISS AND MOTION TO STRIKE

After carefully considering the papers submitted, the Court **GRANTS** Defendant's motions to dismiss and strike portions of Plaintiffs' complaint as follows:

Counts One, Two, Three, and Four are **DISMISSED WITH PREJUDICE**, except for paragraphs 7 and 19.

Paragraph 37 of Plaintiffs' complaint, to the extent it incorporates the allegations in Counts One through Four, except for paragraphs 7 and 19, is ordered **STRICKEN**.

Appendix E

That portion of paragraph 38 of Plaintiffs' complaint which begins at page 14, line 2, and ends at page 14, line 4, and which states "that its Policy was void for lack of an insurable interest, that it was subject to reformation, or" is ordered **STRICKEN**.

That portion of paragraph 39 of Plaintiffs' complaint which begins at page 14, line 13 and ends at page 14, line 14, and which states "that its Policy was void for lack of an insurable interest, that it was subject to reformation, or" is ordered **STRICKEN**.

That portion of paragraph 40 of Plaintiffs' complaint which begins at page 14, line 19 and ends at page 14, line 22, and which states "Bussell's lack of an insurable interest in the Provident and John Hancock Policies, and/or Provident's and John Hancock's unilateral mistakes as to the amount of other disability insurance which he held, and/or" is ordered **STRICKEN**.

Paragraphs 1, 2, 3, and 4 of Plaintiffs' prayer for damages are ordered **STRICKEN**.

Defendant shall have twenty days from the date of this order to answer the remaining allegations in Plaintiffs' complaint.

The Court sets forth the reasons for its ruling below.

I. *Statement of Facts*

Plaintiffs Provident Life and Accident Insurance Company ("Provident") and John Hancock Insurance

Company ("John Hancock") filed their complaint for declaratory and restitutionary relief on March 18, 1994. Plaintiffs allege that they each issued disability insurance policies to Defendant in July 1988 and November 1989, respectively. They further allege that Defendant was injured in September 1992 and that he subsequently made claims for benefits for total disability under both policies.

Plaintiffs seek rescission, or alternatively, reformation of their policies, and restitution of benefits paid as a result of Defendant's claim on three grounds. First, Plaintiffs allege that Defendant's combined disability benefits exceeded his income when he applied for Plaintiffs' policies, that Defendant therefore lacked an insurable interest under California Insurance Code § 280, and thus the policies are void as a matter of public policy. Second, Plaintiffs claim that they issued their policies as a result of a unilateral mistake as to the amount of Defendant's income and the existence of other insurance, and that therefore, had they known the truth, they would not have issued the policies. And third, Plaintiffs contend that Defendant has not suffered a total disability.

Defendant's motion to dismiss and motion to strike is directed at the first two theories proffered by Plaintiffs. These motions seek to dismiss the First, Second, Third, and Fourth Counts on the ground that they fail to state claims on which relief can be granted under Fed. R. Civ. P. 12(b)(6), and to strike portions of the Sixth Count on the ground that those portions are immaterial under Fed. R. Civ. P. 12(f).

Appendix E

II. *Analysis*

As a preliminary matter, the Court notes that it is appropriate for Defendant to bring the following motions to dismiss and strike because these motions implicate purely legal issues only.

A. *Defendant Had an Insurable Interest When He Applied for Plaintiffs' Policies*

California Insurance Code § 10110.1(b) expressly provides that "[a]n individual has an *unlimited insurable interest* in his or her own life, health, or bodily safety and may lawfully take out a policy of insurance on his or her own life, health, or bodily safety and have the policy made payable to whomsoever he or she pleases, regardless of whether the beneficiary designated has an insurable interest." (emphasis added). However, Plaintiffs contend that because Defendant was already insured under other insurance companies' policies for amounts in excess of his earnings, Defendant had no insurable interest at the time he entered into the contracts with Plaintiffs and therefore, the contracts are void as a violation of public policy. Cal. Ins. Code § 280. Plaintiffs base this argument on their claim that an insurable interest in a disability policy is limited by an insured's "reasonably anticipated earning potential." In support, Plaintiffs cite *Jimenez v. Protective Life Ins. Co.*, 8 Cal. App. 4th 528, 540 (1992), where the court held that a creditor's insurable interest in the life of his debtor in "the amount of the debt, plus the refund of the initial premium, plus interest on those two amounts." Plaintiffs contend that, like the debtor in *Jimenez*, Defendant can only recover the

amount of his insurable interest, which, at the time of the contract, was nothing.

The Court disagrees with Plaintiffs' analysis here. Aside from the fact that their position contradicts the plain meaning of Section 11010.1(b), Plaintiffs' argument also fails because the California legislature apparently made a distinction between the insurable interest one has in one's life, health, and bodily safety as opposed to another's. While Section 11010.1*(b)* states that an insured has an unlisted interest in his or her own "life, health or bodily safety," Section 11010.1*(c)* limits one's insurable interest in the life, health or bodily safety of another person to "an interest based upon a reasonable expectation of pecuniary advantage." The California legislature could have placed this same limitation with respect to an insured's interest in his or her own health, but decided not to do so. Thus, the *Jimenez* case, which analyzes a person's interest in another's life, does not apply to the facts of this case.

Therefore, as a matter of law, Defendant had an insurable interest at the time he entered into the disability policies with Plaintiffs.

B. *The Incontestable Clauses in Plaintiffs' Policies Preclude Plaintiffs from Disputing Statements in the Policy Applications*

California Insurance Code § 10350.2 requires disability insurers to include "incontestable clauses" in their policies; these are provisions in an insurance contract that preclude the insurer from challenging the validity of any statements

made by the insured at the time of application after the policy has been in effect for three years. The rationale for such clauses was set forth by the Ninth Circuit in *Richardson v. Travelers Ins. Co.*, 171 F.2d 699, 701 (9th Cir. 1948):

> "Too often has an insurer obtained a judicial determination upon maturity of a policy that the insured had made an inaccurate statement in this application, or was guilty of fraud which resulted in the avoidance of liability under the policy. [citation omitted] The clause remedied this situation by rendering the insurer's promise to perform in accordance with the statements and terms in the policy absolute upon the passing of a specified time, expressly subject only to the non-payment of premiums. Many states have evidenced their favor toward the incontestable clause by enacting legislation requiring it in life insurance policies."

Section 10350.2 allows insurance companies to except fraudulent statements from the incontestability provision, but does not mandate such an exception. Indeed, the California Supreme Court has recognized that "[a general] incontestability provision cannot be reasonably construed as either expressly or impliedly excepting an action or defense based on fraud." *Metzinger v. Manhattan Life Ins. Co.*, 71 Cal. 2d 423, 429 (1969) (citing *Dibble v. Reliance Life Ins. Co.*, 170 Cal. 199, 209 (1915)).

Both of Plaintiffs' policies, copies of which are attached to the complaint, contain clauses which preclude Plaintiffs

from contesting statements in Defendant's policy applications after two years from the dates of application. The Provident policy provides, in pertinent part, that "[a]fter this policy has been in force for two years during your lifetime, we cannot contest the statements in the application." Similarly, the John Hancock policy states, in pertinent part, that "[a]fter this policy has been in force for two years during your lifetime and during which you have not been disabled, we cannot contest any statements in the application." It is undisputed that both policies were in effect more than two years prior to Defendant's alleged disability, and both incontestable clauses do not provide exceptions for fraudulent statements made by Defendant.

Clearly, Plaintiffs cannot challenge any allegedly false or fraudulent statements made by Defendant in his application, even in the guise of a purported unilateral mistake on Plaintiffs' part. Nearly six years have passed since Provident issued its policy and began collecting premiums from Defendant. Nearly four and one-half years have passed since John Hancock issued its policy and began collecting premiums from Defendant. Plaintiffs are therefore barred, as a matter of law, from disputing statements in Defendant's Policy applications.

III. *Conclusion*

For the foregoing reasons, the court **GRANTS** Defendant's motions to dismiss and strike.

IT IS SO ORDERED.

Appendix E

DATED: June 10, 1994

s/ David V. Kenyon
DAVID V. KENYON
UNITED STATES DISTRICT
JUDGE

APPENDIX F — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT DENYING PETITION FOR REHEARING DATED AND FILED JANUARY 4, 2000

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 98-55546

DC No. CV 94-1756 RAP

PROVIDENT LIFE & ACCIDENT INSURANCE CO., a corp.; JOHN HANCOCK MUTUAL LIFE INSURANCE CO., a corp.,

Plaintiffs-Counter-Defendants-Appellees,

v.

JOHN A. BUSSELL, M.D.,

Defendant-Counter-Claimant-Plaintiff-Appellant,

v.

THE PAUL REVERE LIFE INSURANCE COMPANY, a corp.,

Defendant-Appellee.

Appendix F

Before: BROWNING and TASHIMA, Circuit Judges, and KING, District Judge.*

The panel has voted to deny the petition for rehearing. Judges Browning and Tashima vote to deny the petition for rehearing en banc and Judge King so recommends.

The full court has been advised of the petition for rehearing en banc and no judge of the court has requested a vote on en banc rehearing. Fed. R. App. P. 35(b).

The petition for rehearing and the petition for rehearing en banc are denied.

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* Honorable Samuel P. King, Senior United States District Judge for the District of Hawaii, sitting by designation.

APPENDIX G — NOTICE OF EVALUATION COMMITTEE OF THE NINTH CIRCUIT COURT OF APPEALS RE: HELP IDENTIFYING CONFLICTS BETWEEN DECISIONS DATED JANUARY 28, 2000

TO: Members of the Court, Bar and Public 1/28/2000

FROM: Evaluation Committee of the Ninth Circuit Court of Appeals

RE: Help Identify Conflicts Between Decisions

Conflicts. The Ninth Circuit Court of Appeals asks for your help in assisting it to identify perceived conflicts between decisions of the court in two circumstances:

• conflicts between two or more unpublished memorandum dispositions, and

• conflicts between a published opinion and an unpublished memorandum disposition.

Form. A form for notifying the court of the existence of a possible conflict between decisions is available for download at the bottom of this page. You may mail, e-mail, or fax your completed form back to the court. If possible, your response would be appreciated by March 31, but the court would also welcome responses at any time.

Evaluation Committee Efforts. The Evaluation Committee of the Ninth Circuit Court of Appeals is undertaking this effort to identify and remedy possible inconsistencies in circuit law as part of the court of appeals' broader ongoing response to issues and concerns raised by the Final Report

of the Commission on Structural Alternatives for the Federal Courts of Appeals (available online at *http://app.comm.uscourts.gov.*)

Perception of Conflicts. The Ninth Circuit decides nearly 4,500 cases each year; one-fifth of the cases are decided by a formal, written, signed, published opinion, while four-fifths are decided by shorter, written, unpublished memorandum dispositions which are only provided to the parties in the case (and can usually be found on Westlaw or Lexis).

Some judges and attorneys who practice before the court reported to the study commission and in surveys that they thought that the Ninth Circuit Court of Appeals may have some difficulty maintaining consistency among its decisions because of the large number of cases that it decides each year. While two scholarly empirical studies that have examined the issue concluded that no such problem exists, the court is conducting this self-examination to obtain specific examples so it can try to remedy any perceived problems.

If you are aware of conflicts between decisions of the type described above, please assist the court by completing the *form* and returning it at your earliest convenience. Thank you for helping us to improve the administration of justice!